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The Therapeutic Community in a County General Hospital

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• **The past decade has witnessed an enlightened revision in the treatment of the mentally ill. The new approach purports that the hospitalized patient is more effectively treated in open units attached to general hospitals in the local community. Social interaction based on mutual trust and respect for the individual is facilitated in an atmosphere of enhanced communication potential. The improvement of patients in all diagnostic categories seems to justify the enthusiasm for advocating the therapeutic community philosophy in units of a general hospital.**

THE THEORY of hospital treatment of the mentally ill is in the exciting throes of change and re-evaluation. The pendulum is swinging away from large authoritarian locked institutions to smaller unlocked more permissive units in general hospitals. Here, the mentally ill retain the rights and dignity of the physically ill and the stigma is diminished. This paper will attempt to describe the application of the therapeutic community concept to a psychiatric receiving unit in a county general hospital, and describe the therapeutic impact in such a setting.

Evolution and Philosophy

The concept of the therapeutic community was formally elaborated by Jones[1] after World War II following his experiences in affecting social attitudes of patients with largely desocialized character problems. The elements of his method derived from the heightened interest in socio-psychological process as an important agent in the treatment setting. His patients participated in a permissive group living experience which emphasized the social factors in aspects of their illness. Self control, trust and unrestricted communication replaced rigid authoritarian controls. In 1955, Wilmer applied the principles of a therapeutic community to the receiving unit of the U. S. Naval Hospital at Oakland, California, and enhanced the understanding of patient treatment in such a setting. Later in reporting on this work he said: "This type of management opens up the possibility of therapy through social interaction with patient-staff involvement affording potentialities for social development and identification with the group."[7]

A precise definition of a therapeutic community is a difficult task, for such a concept may imply many things. Each unit of this type tends to develop its own personality, depending on the particular needs that it is designed to meet. The essence of the patient experience may be viewed as "reeducation for life."[4] The social and interpersonal difficulties of daily group living comprise a milieu which is conceived in terms of its "resemblance to life for real."[4] Herein lies the potential for group morale and increased social awareness. To achieve this there must be "unrestricted communication between patients and staff with maximum utilization of the healthy part of the personality."[10] The traditional institutional hierarchy is modified by diminishing

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social distance between staff and patients while promoting "equal status participation" as members of the community. The atmosphere is not unlike the esprit de corps of a town hall meeting where everyone feels he belongs and may speak his mind. A community living group favors patient identification with a meaningful social unit and the gradual incorporation of its value system. Patients may then begin to employ the norms of this new reference group in more objectively viewing the self in terms of the reactions aroused in others; and this can lead to an enhanced social consciousness.

The Ward and Personnel

This communication is based on the author's observations in a year of association with a 30-bed therapeutic community in the county hospital in San Mateo, California. The hospital is the acute treatment center serving a population of 450,000. The open door unit, begun in December, 1956, was based on the theory that the mentally ill could best be treated as near to their homes as possible.* Over 120 patients are admitted to the ward each month for evaluation or treatment. The average term of confinement is seven to ten days, although patients may stay up to 90 days. Admission screening includes pre-admission home visits for evaluation before commitment hearings and 24-hour psychiatric coverage in the emergency room. As the ward is the receiving unit for any acute psychiatric emergency in the county, little screening other than in the above cases, is possible. The staff is composed of six therapists (three staff psychiatrists, two residents and an intern), twenty nursing personnel (seven registered nurses, nine licensed vocational nurses and four male attendants) divided over three eight-hour shifts, three social workers, one occupational therapist and two office secretaries.

The ward atmosphere tends to be friendly, permissive and informal. Members of the staff do not wear uniforms or any other differentiating symbol of authority. Patients are permitted to keep all personal belongings with the exception of liquor, razor blades, personal medication and money over the amount of five dollars. The general expectation is that of success. Staff members enthusiastically believe in what they are doing and that the approach is effective.

Symbolism of the Open Door

The open door is first a symbol of trust in patients as responsible persons. It carries the implication of freedom of choice combined with the expectation of self-restraint. In addition it minimizes the isolation of patients from their families and the community from its responsibilities; for example, relatives and friends of patients may visit any time between the hours of 10 a.m. and 9 p.m. Locked doors, by shutting patients in, and society out, imply that there is something to be feared. The open door therapeutic community confronts society with its problem and attempts to deal with its guilt. "The mentally ill deserve to be heard and sometimes the community has to listen whether it prefers to or not."[10]

Concept of the Program

A. The Admission Procedure

Admission is a crucial period for both the patient and his family. Following an evaluation in the emergency room, both the patient and his family are escorted to the ward by the physician and introduced to the admitting nurse, who greets the patient in a friendly manner. Following this, the patient is introduced to patients who have been specially designated to welcome newcomers, and through them to other members of the group. The orientation procedure initiated by the nurse is an essential first step of acculturation. The admitting nurse has a strategic opportunity to convey the theme of trust, mutual respect and honesty which are the basic ingredeints of the culture. The family is introduced to the social worker, and, if possible, an initial interview is held. Treatment can be greatly facilitated if the apprension of admission of both the patient and his family is dealt with as soon after arrival as possible.

B. The Community Group Meeting

The cornerstone of the program is the community group meeting—the therapeutic leveller and sounding board for thoughts and feelings. The community group is not synonymous with the traditional concept of group therapy. The community meeting, comprised of as many as fifty patients and staff, may include a wide range of subjects such as administrative matters, ward routines, and the vast complex of interpersonal difficulties that arise when a group of individuals live together. ". . . the individual responds according to his own particular pattern; in the discussion he realizes that there are other possible ways of reacting. . . ."[3] The ultimate goal of the meeting is to enhance the capacity of the self to effectively relate to others.

The fuel for discussion is *feed-back*. This means accurate rechanneling of observations pertaining to events on the ward and patients' behavior, "Patients and staff must have access to the total body of relevant knowledge in the life of the institution"[9] in

*The unqualified support of Dr. H. D. Chope, M.D., M.P.H., the director of the San Mateo County Department of Public Health and Welfare, was perhaps the most important factor both in inaugurating and maintaining the open door policy in the face of the determined resistance that greeted the new program within the hospital and in the local community.

order for the group to realistically confront the individual with his behavior. Often the patient may discover that "the community deals with his problems in a much more tolerant way than does his own conscience."[2] Feed-back is an important function of the nursing staff, who are in a position to observe the tone of the ward over the 24-hour period. The culture is maintained by the staff in conjunction with a patient core group made up of those who are in hospital for a relatively long term (up to 90 days). The latter are selected on the basis of their ability both to enhance the program and to benefit from it. The community meetings that usually are of most therapeutic value are those in which the group identifies, and resolves in agreement, the problems originating in the interpersonal tensions of a group living experience.

The physician, in his role as group leader, attempts to elicit the feeling tone of the group, to stimulate and facilitate maximum participation, and to comment upon and relate the observed interaction to relevant events in the social context in a nonthreatening yet precise manner. It is essential that he not intrude upon the spontaneity of the discussion. Over-participation or deep analytic interpretations by the physician tend to curtail spontaneous communication by the patients. The therapist should address his remarks to the ego of the group. Meetings may be organized as indicated when acute situations or heightened tension arise on the ward. Such meetings are frequently held in the evening.

The daily group meeting is followed by a half-hour staff discussion. The material of the preceding meeting is processed further and other relevant observations are tied in. The staff meeting ideally is an elastic learning experience, a place for definition, and a time for resolution of staff tensions and dissension. Frequently the patients assemble a spontaneous discussion of their own to further evaluate the content of the preceding meeting.

Patients are divided into three smaller and more closely knit groups of about ten patients and three staff members who meet on three afternoons each week. In this more intimate setting they have a further opportunity to resolve the issues brought forth in the large community group.

C. The Role of the Patient

The implicit expectation is that patients, given the opportunity, can accept the responsibility for their own appropriate behavior. They are expected to do the best they can in the way of active participation in the groups. The responsibility for socially acceptable behavior extends beyond the self to assisting others less able to institute controls from within. There is an abundant therapeutic resource in patient to patient relationships which may be tapped and utilized to enhance the entire program. Patients assume important roles as elected officers in the patient "steering committee" which organizes household routine, door watch, mealtime duties and activity planning.

D. The Place of Individual Therapy

Individual therapy has a distinct and important place in a therapeutic community. Current interpersonal difficulties can be effectively handled in group meetings, but the more deeply rooted personal difficulties are better evaluated and managed individually. The more inhibited members of the group may well discuss privately what they could not bring out in the group. Individual therapy does not seem to appreciably diminish investment in the group; in fact the two are more likely to be complementary. With additional insight achieved through psychotherapy, patients are often better able to make more meaningful contributions in the group sessions. However, there is a danger that some patients will evade the difficulties which arise in their ward relationships by only discussing them in the individual interview. Such evasion should be discouraged and the patient urged to redirect group living problems to the community meeting where they are most effectively handled. Patients receive one and a half to two hours of psychotherapy a week and attempts are made to see each of them for ten minutes on days when they are not scheduled for formal interviews.

E. The Somatic Therapies

Tranquillizing drugs are used as freely as necessary, for this may allow the more disturbed patients to become more amenable to the reality-oriented forces of the group.

The use of sedatives and hypnotics is largely discouraged. Eighteen per cent of the patients received them, mostly for delirium tremens, withdrawal symptoms in drug addicts, and epilepsy. Excessive use of sedatives tends to be an index of anxiety in the staff rather than in the patients. It is likely that the approach to therapy on the unit tends to decrease the need for drugs of this order. Rarely are sedatives and hypnotics used for complaints of insomnia or anxiety; but rather the patients are urged to seek out the sources of their difficulty by talking to the staff rather than diminish the urgency to deal with it by the temporary relief that can be obtained by taking a drug.

Electroconvulsive treatment was used in only six of over 1,650 patients admitted in the year July 1, 1960 to June 30, 1961. Three were manic depressive, two were psychotic depressive and one was schizophrenic. Electroshock, although placing additional demands on nursing time, did not seem to appreciably affect the therapeutic milieu. There can often

be resistance to electroconvulsive therapy in a therapeutic community because the staff often views it as a final gesture when the socio-psychological approach has been unsuccessful. There is a basic fallacy in overenthusiasm for one concept impairing objectively for another. The very flexibility so fundamental to the concept of the therapeutic community suggests that it lends itself to the use of any ancillary therapy. It should be reasoned that a therapeutic community diminishes the need but does not do away with electroconvulsive therapy when it is indicated.

The community concept of self control and group reference control coupled with adequate chemotherapy and attentive nursing care has resulted in the fact that seclusion and restraints were rarely necessary on the ward.

F. Visitors to the Unit

An important facet of the program was the increasing frequency of outside visitors to the community meetings. These included, among others, many professional visitors both from this country and abroad, local psychiatrists and other physicians, a superior court judge, members of the grand jury, a sheriff's deputy, writers, and nonpsychiatric personnel in the hospital. Visits such as these tend to facilitate communication and understanding between representatives of the community and the mentally ill as well as diminish the barriers between patients and the outside. The visits of medical personnel often seemed to increase their understanding of psychiatric patients.

G. Discharge and Referral

One of the primary goals of short-term hospitalization is motivation for out-patient follow-up care. Strong group transference leads to the problem of intense separation anxiety for many patients, and this should be dealt with before the patient is discharged. Whenever possible, initial out-patient appointments are made before the patients leave. It is significant that many former patients make lasting friendships on the ward and continue to see each other following discharge. Many of them return to the ward to visit the staff.

H. Working with the Relatives

Pathogenic environmental factors in the patient's illness should be evaluated and altered when this is possible. If the interpersonal influence in mental illness is a valid concept, then relatives must indeed be viewed as participants in the pathological process and included in the treatment regime. Almost all relatives are seen by the social service and it is not uncommon for a family member to be seen in casework simultaneously with the patient's hospital stay. It is vital that they be acquainted with the problem and helped to deal with it realistically. Spouses' group meetings, where common problems are discussed, are held weekly right on the ward. Again, this serves to point out the relatives' involvement and responsibility in the therapy process.

Often, just before the patient is discharged a joint interview is held with the patient, his family and the physician so that residual communication problems can be dealt with openly. The degree of awareness and involvement of relatives closely corresponds to the ultimate prognosis of the patient.

I. Problems in the Program

It is often difficult and sometimes impossible to gear the program to the needs of acutely disturbed, uncontrolled and physically powerful psychotic patients. Staff members frequently find themselves frustrated, for the use of physical restraint is perceived as disruptive for the ward community. As these potentially violent people cannot be dealt with safely in the permissive atmosphere of a ward community, they are probably best handled in a locked facility with adequate numbers of male attendants to cope with them. An estimated six to eight patients each year have had to be transferred to the state hospital because of management problems.

Verbally uncontrolled psychotic patients often present problems in the community group. Their profuse stream of talk shuts out other patients and may destroy the value of the meeting. Not only has it a disruptive effect on the group, but it also isolates the patient even further from others. If sufficient limits cannot be instituted from the group, then these patients are best excluded temporarily, and worked with individually.

Roles must be continually re-defined. Nursing staff members have difficulty overcoming the vestiges of the traditional professional hierarchy. They tend to feel that they will be criticized for their contributions to group meetings. It is important that they become secure in their role in feedback, with freedom to express their thoughts about patient management without feeling totally subservient to the physicians' wishes.

Ideally, the delicate balance between permissiveness and rigid direction is achieved. It is common, however, to be overly permissive, which can lead to insecurity and anxiety in both patients and staff. *Permissive* means that patients may feel free to *say* whatever they please; it does not imply that they are free to *do* whatever they please.

Because the ward facilities are frequently overtaxed by the high admission rate, it has been occasionally necessary to discharge some patients prematurely in response to the pressure for beds.

TABLE 1.—*Data on Nature of Illness, Length of Stay and Results on Sampling of First Admissions of Patients Accepted for Treatment on the Therapeutic Community Unit. Patients Brought in on Detention Papers for Evaluation Only, Pending Commitment Hearing, Not Included.*

Nature of Illness	Number of Patients		Length of Stay (Days)	Improvement† Noted in	
	No.	Per Cent		No.	Per Cent
Character and personality disorders	56	26.9	7.9	21	37.2
Acute brain syndrome	66	31.8	4.7	47	71.2
Chronic brain syndrome	11	5.3	6.4	5	45.5
Neurotic disorders	48	23.1	6.6	44	91.7
Psychotic disorders (schizophrenic reaction)	27	12.9	24.4	23	85.4
TOTALS	208	100.0	8.9	140	67.3

*Sample includes one-third of total admissions from June 1960 to June 1961. Data were taken at random from the record file.

†The improvement ratio is based on the subjective judgment of the physician involved, which was generally based on evidence that acute symptoms had subsided and that an improved level of social adaptation had been achieved. In some cases, long-term alteration of the underlying process was achieved. As to the lasting effect of the treatment no adequate follow-up studies have been done. However, 10 per cent of patients had to be readmitted in an average six-month period following discharge.

This frequently leads to a patient's being apprehensive about losing his place.

The lack of an outdoor recreational and grounds area has led some patients to feel confined and bored. The off-the-ward patient activity program—picnics, bowling, movies, sporting events, sightseeing—has partially compensated for the lack of grounds facility.

The intense personal investment of the staff in the concept of the therapeutic community can lead to over-identification and intense involvement with patients at the expense of objectivity. Over-investment in this kind of program may lead to unrealistic demands on the patient's capacity to respond. The ensuing sense of failure may put an additional burden on an already impoverished patient self-esteem. The problem of staff over-investment or of detachment should be quickly identified and resolved as soon as possible. The staff are not immune to criticism from patients or other staff members. Hidden staff tension often remains covert, and as such may manifest itself by an increase in disturbed patient behavior.

The goal of unrestricted communication is not always easy to achieve because of the highly transient population, covert staff dissension, and the necessity of treating all types of patients on the same ward.

RESULTS

Generally the unit has been able to meet the needs of a large number of patients of all diagnostic categories with some degree of improvement in the psychiatric condition. It must be remembered that the goal of a program of this type is social cure, not personality reorganization. The following statistics are not given as absolute evidence of the efficacy of such a program, but are included to suggest the direction that it is taking. In the year under report, 93 per cent of the discharges from the unit were considered indicated; 70 per cent of the patients discharged in these circumstances were recommended for further follow-up care.

Since the inception of the ward over four years ago, more patients are found to be seeking help voluntarily. In the 12 months under review, 68 per cent of patients admitted were referred by self, by relatives or by friends. Only 40 per cent of admissions were voluntary three years ago.

Since the ward opened, the overall rate of commitment of patients from it to state hospitals has dropped from over 30 per cent to 15 per cent.

In general, it appeared that schizophrenic patients and those with acute brain syndrome (alcohol) and character disorders responded best to the program here described. Persons with character disorders were better able to contend with their social world. Alcoholics were discharged in improved physical and emotional state, and many sought follow-up care at the clinic and with Alcoholics Anonymous. Patients making suicide gestures seemed to benefit from brief hospitalization and an interpretation of their action as a cry for help directed at some significant person. A joint interview with the family helped to facilitate transmission of this message. Even the small group of patients (mostly senile) with chronic brain syndromes could be assisted through helping the relatives to deal with the problem in a realistic manner. (See Table 1.)

The acute schizophrenic patients are of special interest in a therapeutic community because they comprise the majority of patients selected for long-term care on the unit and are perhaps a good barometer of the therapeutic potential. Sixty patients of this order were treated from June 1960 to June 1961. They had not been treated on the permissive ward previously but were having anywhere from their first to fifth overtly psychotic episode at the time of admittance. Almost all remained in the hospital on a "voluntary" basis, although many stayed under threat of involuntary commitment.

Ninety per cent of the schizophrenic patients returned home in remission after relatively brief periods—an average of five and a half weeks. The 10 per cent who were committed were usually too disruptive, aggressive and threatening to respond to the controls compatible with a non-authoritarian program. Only 13 per cent of those who were discharged were readmitted within six months, which suggests that the results that were achieved had some lasting effect. Those readmitted seemed to show that premature discharge and failure to follow through with after care were factors. The therapeutic community is effective with schizophrenics largely because it affords them vast opportunities for reestablishment of ego boundaries and social reintegration.

The program on the unit was essentially standard for all admissions. Eighty-five per cent of the patients were given the triad of drug therapy, group therapy and individual therapy.

DISCUSSION

An open door therapeutic community can be effectively applied to a psychiatric receiving unit in a county general hospital and can achieve the goal of returning many patients to the community as soon as possible—a week or ten days. It is obvious that underlying psychopathology cannot be affected in so brief a period, but nevertheless patients can be assisted through an acute emotional crisis and properly prepared for follow-up treatment after discharge. The unit's location right in the community confronts society with its responsibility to the mentally ill and diminishes the unhealthy isolation of treatment in far off impersonal state hospitals. The availability of a local treatment resource results in more people seeking help voluntarily.

Although treating all kinds of patients for brief periods on one ward results in increased pressure on the staff and makes for difficulties in maintaining the therapeutic milieu, effective treatment results can be achieved. The dangers that present themselves in such a unit are over-enthusiasm at the expense of objectivity, intense and often exhausting staff investment, and failure to resolve staff tension.

All the formal modes of therapy are applicable to the therapeutic community. The principles of honesty, trust, and self-respect in an atmosphere of relatively unrestricted communication and social interaction have particular meaning to schizophrenic patients, who seem to respond extremely well.

The material presented in this paper is largely impressionistic and descriptive in nature. It is essential that therapeutic community units in general hospitals be subjected to further systematic study under the rigorous dimensions of scientific methods before the full impact of such a treatment program may be demonstrated.

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